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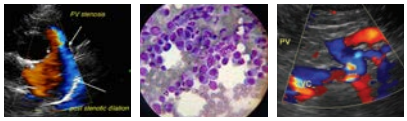

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DATE

9/3/21

PATIENT

BB Campbell

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

2008

WEIGHT

7 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Alayon

INVOICE

25188

PRESENTING CLINICAL SIGNS

Referral
History: of suspected pancreatitis often responds to meds/outpatient
this time still vomiting, referred for continued care. Abdomen- concern for loss of detail and non-regenerative anemia rest of lab work unremarkable.

Current Medications: Maropitant Citrate (Cerenia) Tablets 24mg, Gabapentin Capsules 100mg, Oral Buprenorphine 0.3mg/ml, Pantoprazole (Protonix) 40mg/vial Injection (Per mL), Ketamine 100mg/mL, Acepromazine 10mg/mL Injection (Per mL).
Lab Results: Attached separately.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney is hyperechoic, but has intact corticomedullary distinction and normal shape and size (3.4 cm). There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.95 cm). It is hyperechoic but has normal corticomedullary distinction. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a minimal amount of intraluminal debris. The common bile duct is severely dilated and tortuous, measuring 0.52 cm at maximal measurements. No obvious site of obstruction noted. The dilation can be followed to the duodenal papilla, and it measures 0.37 cm at the duodenal papilla. Upon close inspection, there may be some mucoid material within the bile duct, and a small 0.25 cm non-obstructive stone.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.21, 0.27 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with severe pancreatitis. The pancreatic duct measures 0.22 cm.

Free Abdomen

Evaluation of the peritoneal cavity revealed scant anechoic free fluid. No lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of increased echogenicity around the pancreas.

PRIMARY FINDINGS

- Large, hypoechoic pancreas with surrounding hyperechoic mesentery and free abdominal fluid – The pancreatic changes are most consistent with severe pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.

- Dilated tortuous bile duct – No obvious obstruction is visualized, but a possible mineralization is visualized, and the pancreas is severely inflamed.

SECONDARY FINDINGS

- Mildly prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

- Small volume free abdominal fluid – suspect this is inflammatory secondary to the pancreatitis. If the volume increases, recommend sampling for cytology and fluid analysis.

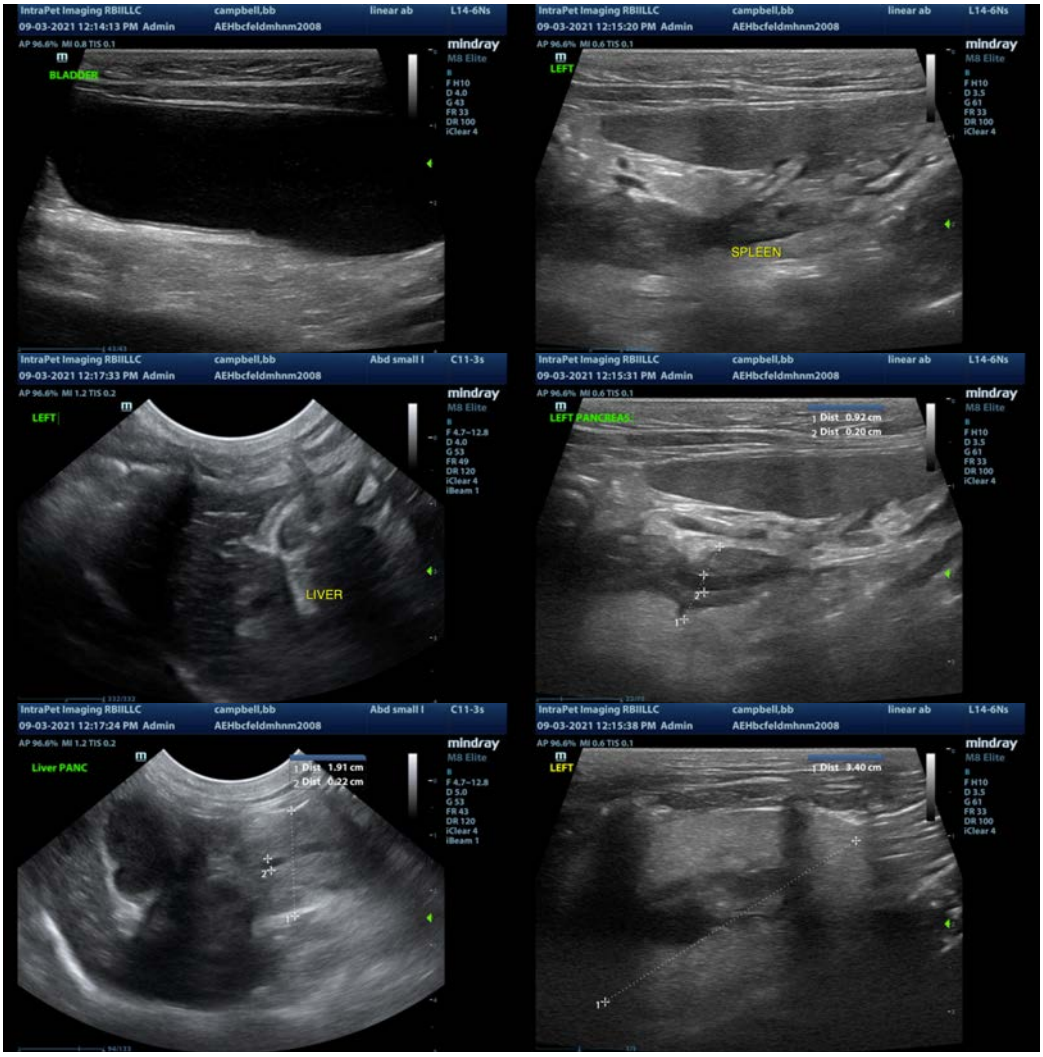
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

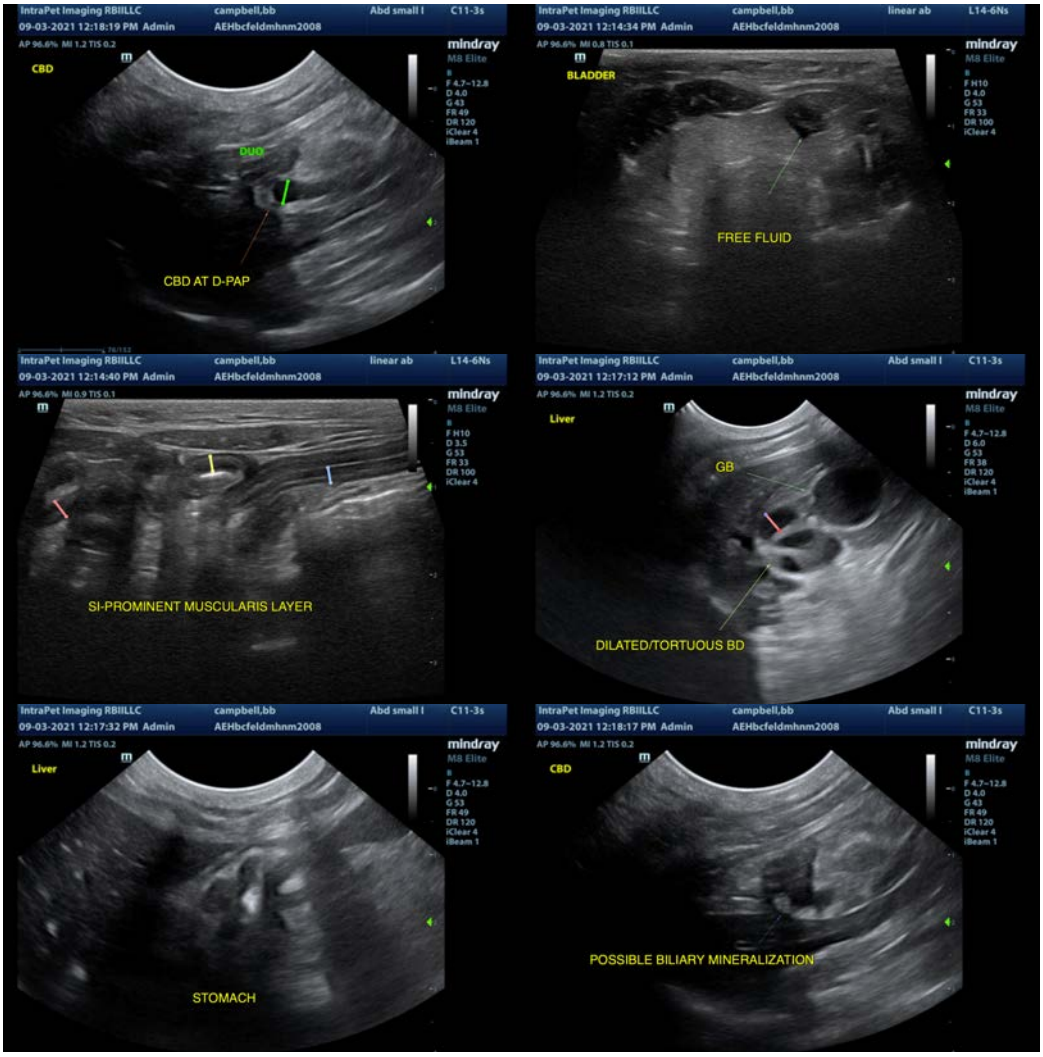
The pancreas is very prominent and appears severely inflamed. I suspect this is the primary problem, but concurrent small intestinal and biliary disease is likely. In the absence of elevated liver values or an elevated bilirubin, I would recommend monitoring these values and the bile periodically, but this could be from a

previous episode of obstruction.

- Recommend GI panel with quantitative fPLI, B12 and folate to evaluate the pancreatitis further and to evaluate for concurrent small intestinal disease.
- Recommend aggressive treatment for acute pancreatitis (there is likely a chronic component to this as well).

An obvious cause for the anemia is not observed. This could be an extreme anemia chronic disease. Recommend a pathologist review of the CBC to look for abnormal cells or parasites. Recommend mycoplasma testing.





The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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